## HEALTHCARE REGULATORY ROUND-UP #90

# Tightening Your Belt:

## Prepare for Medicare Site-Neutral Payment Reform

**March 5, 2025**

# Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
  - If question not addressed during webinar, will follow-up via e-mail
- Enlarge, rearrange, or close panels as you prefer
- For technical difficulties, try refreshing browser first

# Introductions

**Martie Ross**
Principal
mross@pyapc.com

**Kathy Reep**
Senior Manager
kreep@pyapc.com

PYA
pyapc.com
800.270.9629

ATLANTA | CHARLOTTE | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

# Today's Agenda

1. What Are Site-Neutral Payments?
2. Why Worry Now?
3. Why Different Rates for Different Locations?
4. What Proposals Are Under Consideration?
5. Now What?

# 1. What Are Site-Neutral Payments?

# Site Neutral Payments

- Same payment for same services regardless of site of service subject to patient safety and quality safeguards
  - Furthering the distance between provider's cost of furnishing a service and reimbursement for that service
- Examples
  - Hospital inpatient-only list, list of covered ambulatory surgical center (ASC) services
  - Hospital outpatient department (HOPD) vs. ASC vs. freestanding physician clinic
  - Unified payment rate for post-acute care (home health, skilled nursing facility, inpatient rehabilitation facility, long-term care hospital)
  - SNF vs. critical access hospital (CAH) swing bed
  - Geographic adjustments

# Policy Challenges

1. How does one define patient safety and quality safeguards?
2. How does one preserve access to care?
   - Force providers to enhance efficiency, cut costs
   - Provider will furnish service at a loss so long as it can shift costs elsewhere, but what if there's nowhere left to shift?
3. How does one dismantle existing payment methodologies without knocking the whole system down?

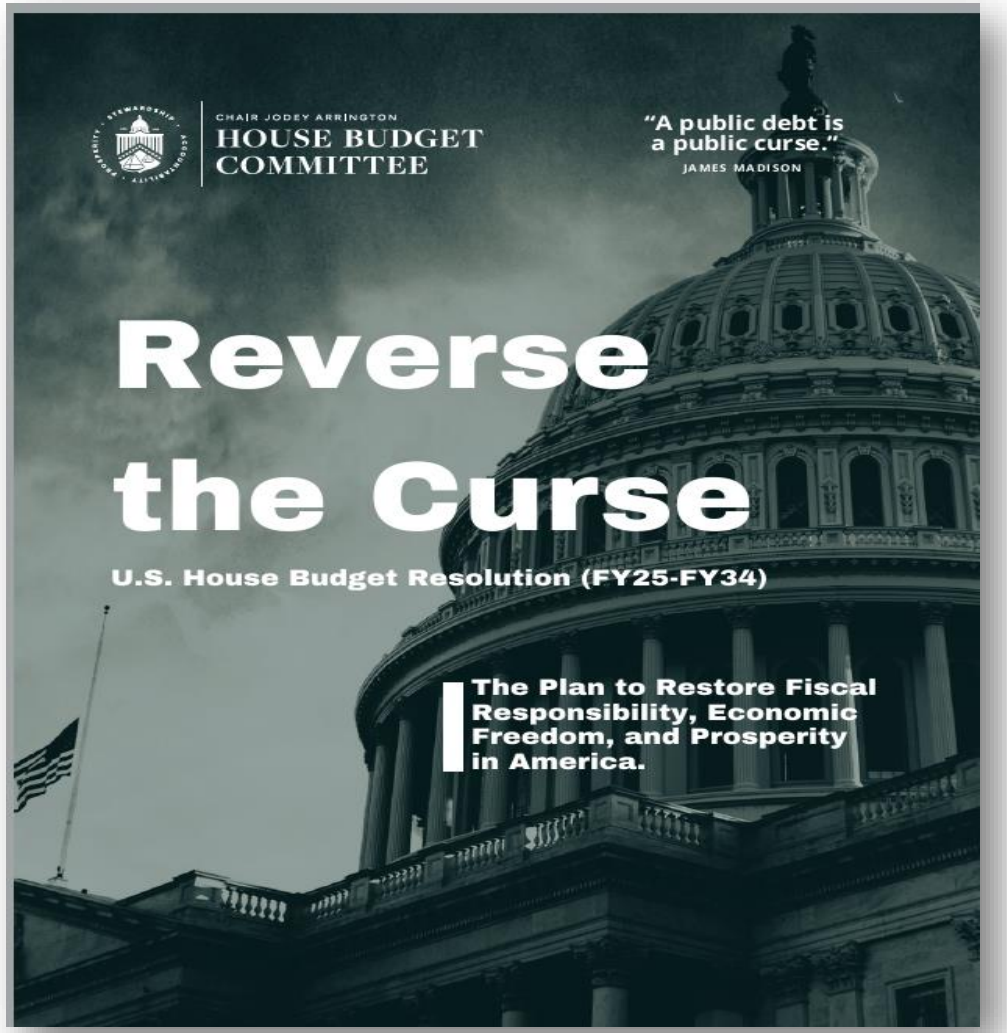
# 2. Why Worry Now?

# House Budget Resolution

- $4.5T in tax cuts
- Instructions to several committees that equal at least $1.5 trillion in cuts to mandatory spending
  - $880B cuts to Energy & Commerce (Medicaid), $230B cuts to Agriculture (SNAP)
  - Committees must submit legislation to House Budget Committee by **March 27**
- Mandate to find another $500 billion in spending reductions without specific committee instructions
- Any shortfall results in corresponding reduction in tax cuts (e.g., if only $1.7B in cuts, tax cuts reduced to $4.2T); any excess results in corresponding increase in tax cuts (e.g., if $2.3B in cuts, tax cuts increased to $4.8T)

# Senate Budget Resolution

- $342B in new funding over four years divided between border security and national defense
- Committees charged with drafting implementing bill to determine funding source (spending cuts)
- Defer tax cut reauthorization to later time




https://budget.house.gov/imo/media/doc/reverse_the_curse_budget_blueprint_fy25-341.pdf

### Creating Payment Parity for the Same Services:

Unnecessary costs in health care are not only breaking the budgets of working families, but they are bankrupting our country. Patients, providers, and taxpayers should pay the same amount for the same service, regardless of the setting. Currently, a hospital outpatient department is paid substantially more by Medicare compared to other delivery settings such as a physician office or ambulatory surgery center. This difference in reimbursement rates for the same services has created a financial incentive for hospital systems to acquire freestanding physician offices, fueling consolidation that reduces competition, drives up costs for patients and limits health care provider choices for patients. This includes payment for lower-complexity services such as office visits, imaging, and drug administration, which the Medicare Payment Advisory Commission (MedPAC) has noted are safe and effective to be delivered in a physician's office.

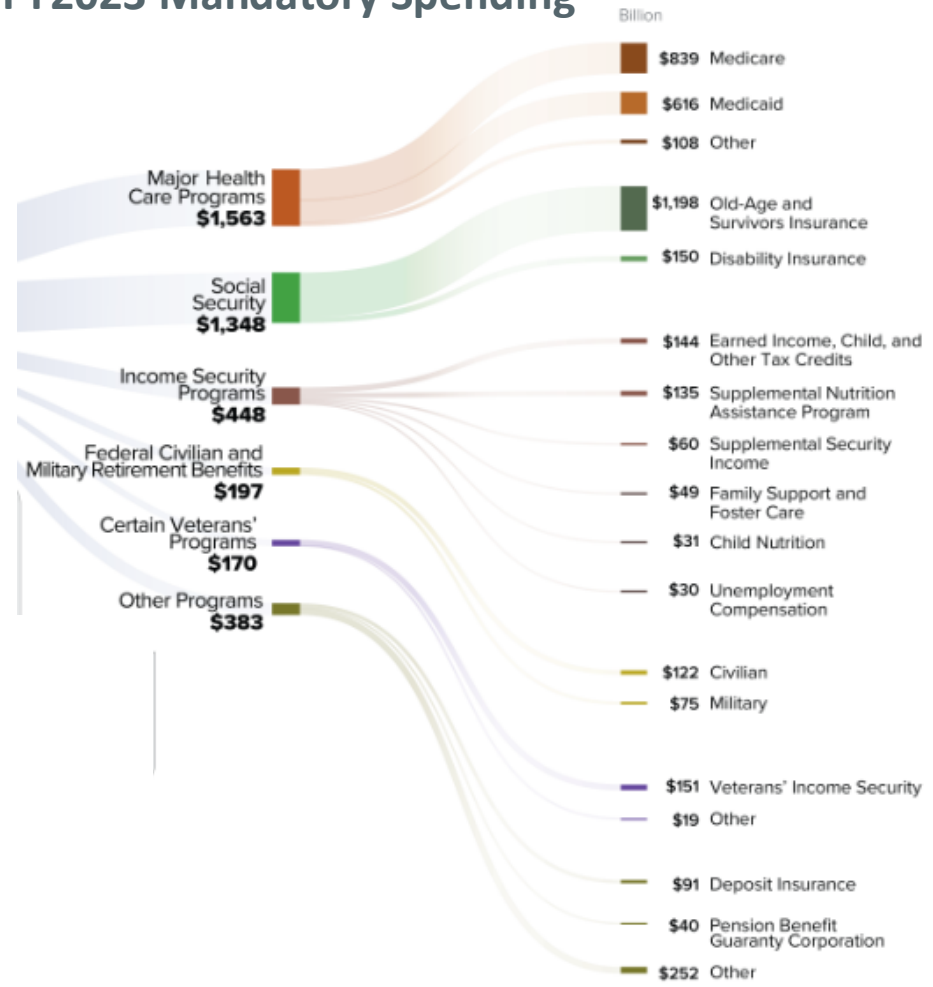
Because Medicare pays more, seniors also pay more in out-of-pocket cost sharing requirements, as well as Part B premiums and deductibles, which are indexed annually to a percentage of program costs. Accordingly, equalizing payments for certain outpatient services will decrease spending in Medicare and reduce costs for millions of seniors. Our budget supports equalizing Medicare payments for health care services that can be safely delivered in a physician's office. [11]

# What Mandatory Spending Will Be Cut?

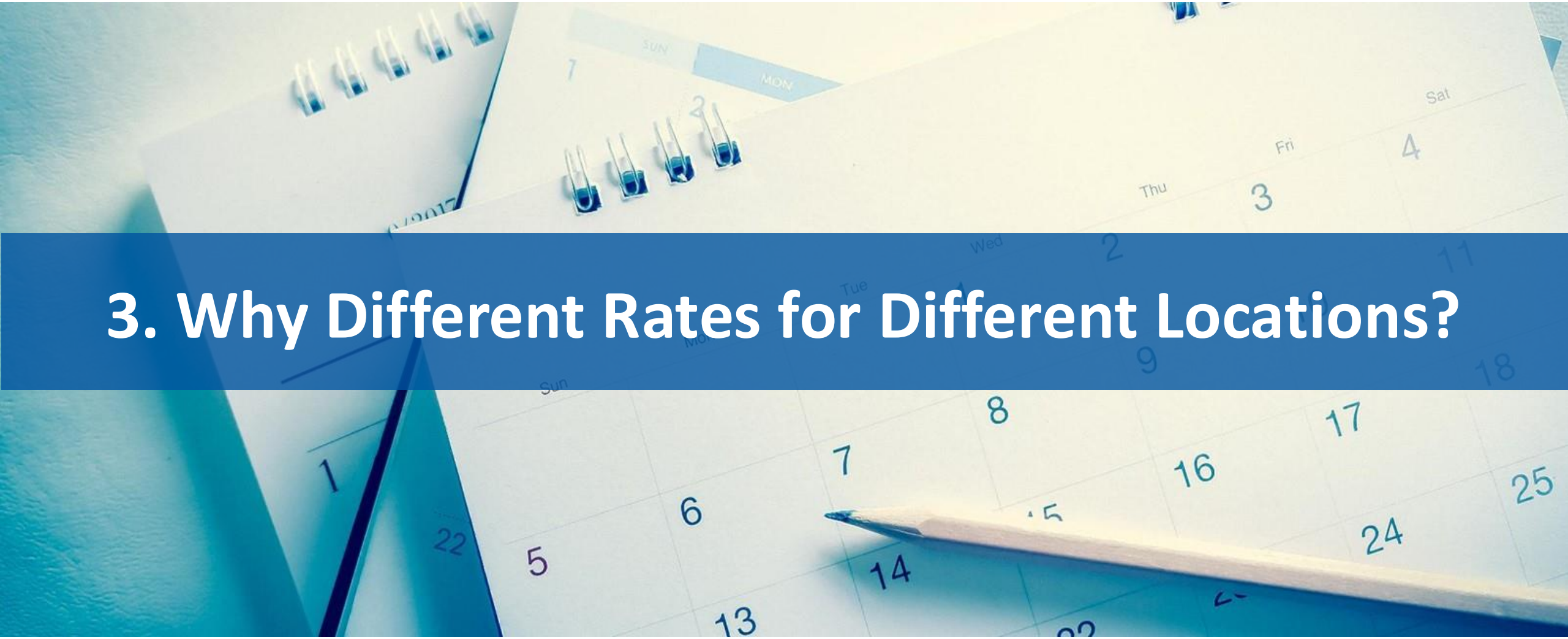
- Social Security benefits off the table
- Medicare benefits off the table
  - But not payments to providers
  - Top of the list: site neutral payment reforms ($146B)
  - Other options
    - Reduce 340B drug payments ($15.4B to $73.5B)
    - Reduce/eliminate bad debt coverage ($16.7B to $54.1B)
    - Consolidate/reduce GME payments ($94B to $103B)
    - Reform UCC payments ($229B)
    - Wage index geographic integrity ($10B)
    - Eliminate hospital dual classification ($10B)
    - Reform Medicare physician payments ($10B)

https://www.hfma.org/wp-content/uploads/2025/01/senate-finance-committee_budget-cuts-menu.pdf

**FY2023 Mandatory Spending**

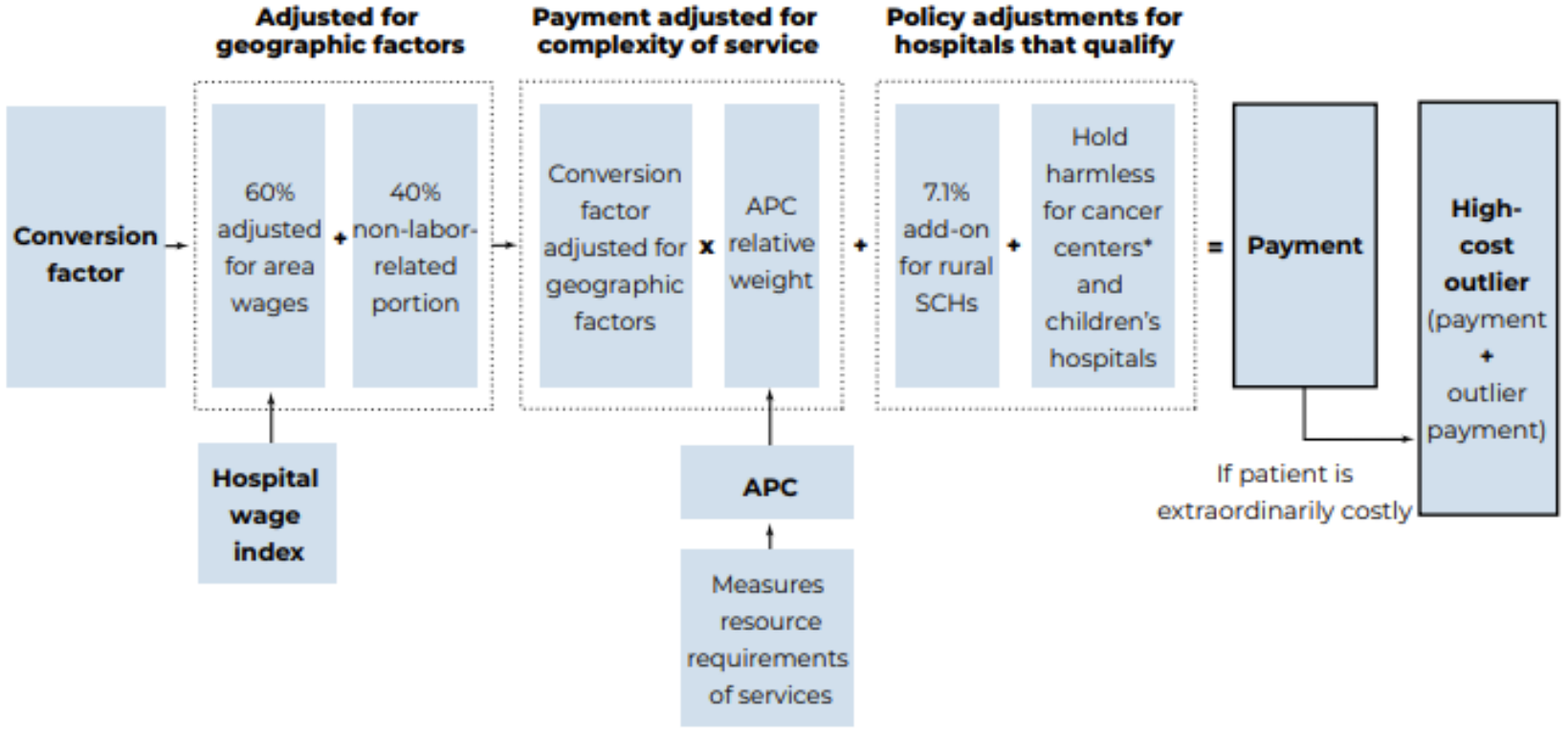



https://www.cbo.gov/publication/59728



# 3. Why Different Rates for Different Locations?

# Hospital Outpatient Prospective Payment System (OPPS)




https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_OPD_FINAL_SEC.pdf

# Conversion Factor

- Base rate intended to represent national average *cost* for average Medicare case
  - Prior to OPPS implementation in 2000, hospitals paid lesser of costs (based on cost report) or charges (beneficiary coinsurance = 20% of charges)
- Based on 1999 Medicare Part B amounts payable plus patient coinsurance, trended forward by annual update factor
  - 60% subject to hospital wage index adjustment
  - Annual update based on hospital market basket index minus multifactor productivity adjustment

# Same Service, Different Medicare Reimbursement

- **Freestanding physician clinic reimbursement**
  - Paid under MPFS at non-facility rate (work RVUs + practice expense RVUs + malpractice expense RVUs)
- **HOPD reimbursement**
  - Hospital paid under OPPS if HCPCS code cross-walked to APC
    - Listed in Addendum B to annual OPPS Final Rule
    - Not all CPT/HCPCS are cross-walked to APC
    - Status indicators prevent duplicative payment
  - Practitioner paid separately for professional services furnished in HOPD under MPFS at facility rate (lower practice expense RVUs)
  - If HCPCS cross-walked to APC, HOPD reimbursement higher than clinic reimbursement
    - However, APC pays for bundle of services, while clinic may bill for multiple codes
- **ASC reimbursement**
  - Limited to procedures on ASC list
  - ASC receives approximately 60% of OPPS rate
  - Practitioner paid separately for professional services furnished in ASC under MPFS at facility rate

NOTE: Lab services paid on separate fee schedule regardless of site of service; mammography and therapies (PT, OT, speech therapy) furnished in HOPD reimbursed on MPFS.

# What Critics Are Saying

- "Drives hospital acquisition of physician practices, which in turn drives up commercial rates"
  - Hospital ownership of physician practices increased from 24.3% in 2019 to 28.4% in 2024
  - Corporate ownership of physician practices (e.g., insurance companies, private equity) increased from 14.6% in 2019 to 30.1% in 2024
- "Results in higher out-of-pocket costs for Medicare beneficiaries"
  - 89% of traditional Medicare beneficiaries have some form of additional coverage (Medigap (42%), employer or union-sponsored retiree health benefits (31%), or Medicaid (16%))
- "Providers need incentives to improve efficiency by caring for patients in lowest-cost site appropriate for condition"
  - Providers still must comply with applicable regulatory requirements (emergency care and standby capacity)

https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/

# Existing Site Neutrality Provisions

- Since 2020, only on-campus HOPDs receive full facility fee associated with evaluation and management (E/M) services (APC 5012)
- Grandfathered off-campus HOPDs continue to receive full facility fee except for E/M services
  - Off-campus HOPDs in existence as of November 2, 2015, and dedicated emergency departments
    - 21st Century Cures Act also provided mid-build exception
    - Grandfathered status extends to expanded operations in existing HOPD
- Non-grandfathered off-campus HOPDs reimbursed at equivalent of freestanding physician clinic rates (calculated as 40% of OPPS rate)
  - But new on-campus HOPDs reimbursed under OPPS

# 4. What Proposals Are Under Consideration?

# Drug Administration and Imaging Services ($5.6 and $7.6B over 10 years, respectively)

- Reduce Medicare reimbursement for drug administration and/or imaging services provided in off-campus HOPDs to equivalent of MPFS reimbursement (~40% of OPPS rate)
  - No exception for grandfathered off-campus HOPDs (similar to E/M services)
  - Will hospitals eliminate service at off-campus HOPDs, thus forcing patients to navigate main hospital campus?
    - Should policy be extended to on-campus HOPDs?

https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf

# Grandfathered Status ($31.2B over 10 years)

- Eliminate grandfathered status for off-campus HOPDs, i.e., reimburse as freestanding physician clinic
- Cost savings nearly 10x greater than drug administration – impact on hospital operations?
  - Relocate services to main campus?

https://www.hfma.org/wp-content/uploads/2025/01/senate-finance-committee_budget-cuts-menu.pdf

# MedPAC June 2023 Proposal ($180.6B over 10 years)

- Methodology
  - Assume site with highest volume of service is appropriate location of care
    - If HCPCS volume highest in freestanding physician clinic, align OPPS/ASC rates with MPFS rates (57 of 169 APCs)
    - If volume highest in ASCs, align OPPS rate with ASC rate (~40% reduction); MPFS rate would not change (9 APCs)
    - If volume highest in HOPD, no change (103 APCs)*
  - For 66 “re-priced” APCs, modify HOPD payment if furnished as part of emergency or trauma care
- MedPAC assumed change would be implemented in budget neutral manner, i.e., rates for other hospital outpatient services would increase
  - Emphasized any change must protect patient access to care and hospitals’ ability to maintain emergency care and standby capacity

https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

# CPT 62323: OPPS vs. MPFS

**TABLE 8–4** Differences in payment rates for epidural injection into the lumbar or sacral regions in physician's office or HOPD, 2023

| Actual 2023 payment rates | | Policy that would align rates across settings | |
|---|---|---|---|
| ***Service in physician's office*** | | ***Service in physician's office*** | |
| Physician work | $59.51 | Physician work | $59.51 |
| Nonfacility PE | $190.43 | Nonfacility PE | $190.43 |
| Professional liability insurance | + $5.95 | Professional liability insurance | + $5.95 |
| **Total payment** | **$255.89** | **Total payment** | **$255.89** |
| ***Service in HOPD*** | | ***Service in HOPD*** | |
| Physician work | $59.51 | Physician work | $59.51 |
| Facility PE | $31.08 | Facility PE | $31.08 |
| Professional liability insurance | + $5.95 | Professional liability insurance | + $5.95 |
| Payment to physician | $96.54 | Payment to physician | $96.54 |
| Payment to HOPD (OPPS rate) | + $644.34 | Payment to HOPD (nonfacility PE – facility PE) | + $159.35 |
| **Total payment** | **$740.88** | **Total payment** | **$255.89** |

Note: HOPD (hospital outpatient department), PE (practice expense), OPPS (outpatient prospective payment system). Payments include both program spending and beneficiary cost sharing. The payment rates in this table are those for Current Procedural Terminology code 62323.

Source: MedPAC analysis of physician fee schedule and OPPS payment rates for 2023.

https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf

**TABLE 8-2**

**Program spending, beneficiary cost sharing, and volume for 57 APCs for which we aligned OPPS payment rates with PFS payment rates, 2021**

| APC | APC description | Program spending (in millions) | Beneficiary cost sharing (in millions) | Volume (in thousands) |
|---|---|---|---|---|
| 5012 | Clinic visits | $2,056 | $514 | 27,835 |
| 5693 | Level 3 drug administration | 879 | 220 | 5,459 |
| 5694 | Level 4 drug administration | 680 | 170 | 2,819 |
| 5524 | Level 4 imaging w/o contrast | 680 | 170 | 1,778 |
| 5593 | Level 3 nuclear medicine | 642 | 160 | 619 |
| 5522 | Level 2 imaging w/o contrast | 632 | 158 | 7,333 |
| 5523 | Level 3 imaging w/o contrast | 547 | 137 | 3,000 |
| 5521 | Level 1 imaging w/o contrast | 453 | 113 | 7,072 |
| 5052 | Level 2 skin procedures | 288 | 72 | 1,048 |
| 5691 | Level 1 drug administration | 283 | 71 | 8,987 |
| 5373 | Level 3 urology and related services | 240 | 60 | 169 |
| 5443 | Level 3 nerve injections | 238 | 59 | 364 |
| 5054 | Level 4 skin procedures | 230 | 58 | 169 |
| 5442 | Level 2 nerve injections | 223 | 56 | 443 |
| 5724 | Level 4 diagnostic tests and related services | 191 | 48 | 267 |
| 5692 | Level 2 drug administration | 189 | 47 | 3,963 |
| 5441 | Level 1 nerve injections | 176 | 44 | 873 |
| 5722 | Level 2 diagnostic tests and related services | 141 | 35 | 671 |
| 5611 | Level 1 therapeutic radiation treatment preparation | 136 | 46 | 1,454 |
| 5051 | Level 1 skin procedures | 102 | 26 | 722 |
| 5822 | Level 2 health and behavior services | 95 | 24 | 1,596 |
| 5053 | Level 3 skin procedures | 78 | 20 | 190 |
| 5734 | Level 4 minor procedures | 77 | 19 | 871 |
| 5071 | Level 1 excision/biopsy/incision and drainage | 76 | 19 | 154 |
| 5372 | Level 2 urology and related services | 69 | 17 | 153 |
| 5723 | Level 3 diagnostic tests and related services | 65 | 16 | 169 |
| 5733 | Level 3 minor procedures | 60 | 15 | 1,360 |
| 5823 | Level 3 health and behavior services | 58 | 14 | 558 |
| 5101 | Level 1 strapping and cast application | 51 | 13 | 454 |
| 5721 | Level 1 diagnostic tests and related services | 49 | 12 | 447 |
| 5153 | Level 3 airway endoscopy | 46 | 11 | 39 |
| 5731 | Level 1 minor procedures | 34 | 9 | 1,751 |
| 5371 | Level 1 urology and related services | 34 | 8 | 160 |
| 5671 | Level 1 pathology | 31 | 8 | 768 |
| 5164 | Level 4 ENT procedures | 29 | 7 | 13 |
| 5741 | Level 1 electronic analysis of devices | 28 | 7 | 955 |
| 5055 | Level 5 skin procedures | 28 | 7 | 10 |

**TABLE 8-2**

**Program spending, beneficiary cost sharing, and volume for 57 APCs for which we aligned OPPS payment rates with PFS payment rates, 2021** *(cont.)*

| APC | APC description | Program spending (in millions) | Beneficiary cost sharing (in millions) | Volume (in thousands) |
|---|---|---|---|---|
| 5481 | Laser eye procedures | $20 | $5 | 52 |
| 5151 | Level 1 airway endoscopy | 16 | 4 | 127 |
| 5111 | Level 1 musculoskeletal procedures | 10 | 2 | 58 |
| 5163 | Level 3 ENT procedures | 8 | 2 | 8 |
| 5732 | Level 2 minor procedures | 8 | 2 | 305 |
| 5743 | Level 3 electronic analysis of devices | 7 | 2 | 34 |
| 5102 | Level 2 strapping and cast application | 7 | 2 | 36 |
| 5161 | Level 1 ENT procedures | 7 | 2 | 41 |
| 5152 | Level 2 airway endoscopy | 6 | 1 | 19 |
| 5413 | Level 3 gynecologic procedures | 4 | 1 | 8 |
| 5411 | Level 1 gynecologic procedures | 4 | 1 | 29 |
| 5412 | Level 2 gynecologic procedures | 4 | 1 | 17 |
| 5162 | Level 2 ENT procedures | 3 | 1 | 9 |
| 5742 | Level 2 electronic analysis of devices | 3 | 1 | 36 |
| 5502 | Level 2 extraocular, repair, and plastic eye procedures | 2 | 1 | 4 |
| 5501 | Level 1 extraocular, repair, and plastic eye procedures | 2 | 1 | 12 |
| 5735 | Level 5 minor procedures | 1 | 0.3 | 7 |
| 5821 | Level 1 health and behavior services | 1 | 0.3 | 66 |
| 5621 | Level 1 radiation therapy | 1 | 0.3 | 12 |
| 5811 | Manipulation therapy | 0.5 | 0.1 | 25 |

**TABLE 8-3**

**Program spending, beneficiary cost sharing, and volume for nine APCs for which we aligned OPPS payment rates with ASC payment rates, 2021**

| APC | APC description | Program spending (in millions) | Beneficiary cost sharing (in millions) | Volume (in thousands) |
|---|---|---|---|---|
| 5312 | Level 2 lower GI procedures | $725 | $181 | 877 |
| 5491 | Level 1 intraocular procedures | 568 | 142 | 343 |
| 5431 | Level 1 nerve procedures | 221 | 55 | 159 |
| 5311 | Level 1 lower GI procedures | 215 | 54 | 339 |
| 5492 | Level 2 intraocular procedures | 212 | 53 | 68 |
| 5112 | Level 2 musculoskeletal procedures | 92 | 23 | 83 |
| 5462 | Level 2 neurostimulator and related procedures | 69 | 17 | 14 |
| 5503 | Level 3 extraocular, repair, and plastic eye procedures | 40 | 10 | 25 |
| 5504 | Level 4 extraocular, repair, and plastic eye procedures | 13 | 3 | 5 |

# Inpatient Only List (IOL) ($10B over 10 years)

- List of services for which Medicare coverage limited to inpatient hospital setting
  - Intended to ensure that complex/high-risk procedures performed in setting with necessary medical resources and support
- First Trump administration proposed, implemented, and then reversed elimination of IOL
  - Initial implementation removed 298 services from IOL
  - Reversed due to patient safety concerns

https://www.hfma.org/wp-content/uploads/2025/01/senate-finance-committee_budget-cuts-menu.pdf

# Expansion of ASC Covered Procedures List (CPL)

- CPL includes those procedures not expected to pose significant risk to patient safety and not expected to require care for more than 24 hours after admission
- Tracks closely with IPL changes
  - Following removal of services from IPL, 267 surgical services added to ASC CPL in 2021
  - All but 6 removed following changes to IPL in 2022

# Unified Payment Rate for Post-Acute Care

- Similar patients admitted to different PAC settings with different payment rates
- Different quality measures and patient assessments make comparing patients across settings difficult
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required CMS to evaluate unified payment system
- Recent changes to SNF and HHA PPS have lessened the need for a unified system

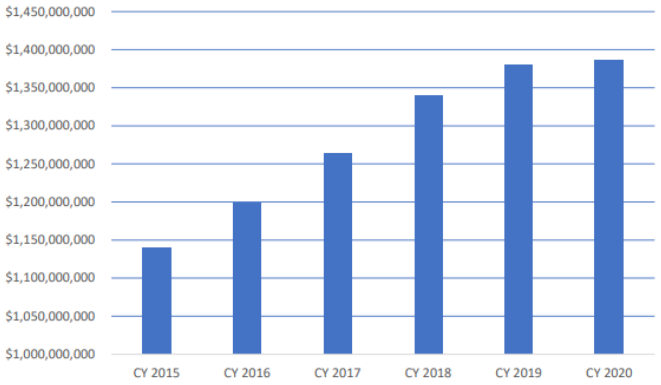
# Reimburse CAH Swing Beds at SNF Rates

Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2024 | A-05-21-00018

**Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System**

**Figure 4: Estimated Amounts That Medicare Could Have Saved Over 6 Years**




OIG: "We recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities."

CMS: "[T]he reduction in payments to CAHs would likely jeopardize the viability of rural hospitals and access to care in other underserved areas."

https://oig.hhs.gov/documents/audit/10151/A-05-21-00018.pdf

# Total Cost Per Episode of Care, Not Daily Rate

- CAH swing bed admissions significantly shorter than SNF admissions
- Fewer CAH swing bed patients readmitted to inpatient care
- More CAH swing bed patients discharged to home
- SNF patients often have separate HOPD charges while at facility
- Because operating costs no longer would be spread across swing bed admissions reimbursement for hospital inpatient & outpatient services would increase

# Provider Designations

- Low Volume Hospitals (enhanced program set to expire on March 31, 2025)
- Medicare Dependent Hospitals (entire program set to expire March 31, 2025)
- Sole Community Hospitals
- Rural Emergency Hospitals

# Commercial and Employer-Sponsored Plans

- Researchers used AHRQ's Synthetic Healthcare Database for Research (SyH-DR) to estimate impact of commercial and employer-sponsored plans adopting MedPAC site neutrality recommendations
  - 2022 savings in employer market: $58.2B
  - 10-year premium reduction: 5.0 to 5.35%
  - 10-year total increase in federal tax revenue: $139.7B
- State and federal legislative proposals to prevent hospitals from charging "add-on" fees
- Changes in negotiating position following Medicare site neutral payment reform

Parente ST. Impact of Site-Neutral Payments for Commercial and Employer-Sponsored Plans. Inquiry. 2024 Jan-Dec;61:469580241275758. doi: 10.1177/00469580241275758. PMID: 39188172; PMCID: PMC11348360
https://pubmed.ncbi.nlm.nih.gov/39188172/

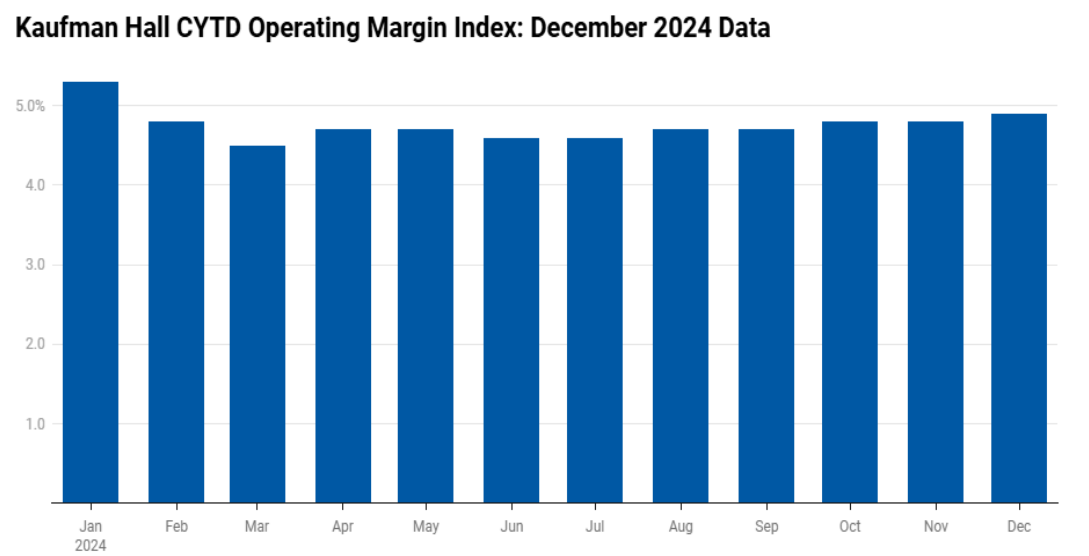
# 5. Now What?

# Know Your Numbers, Identify Your Options

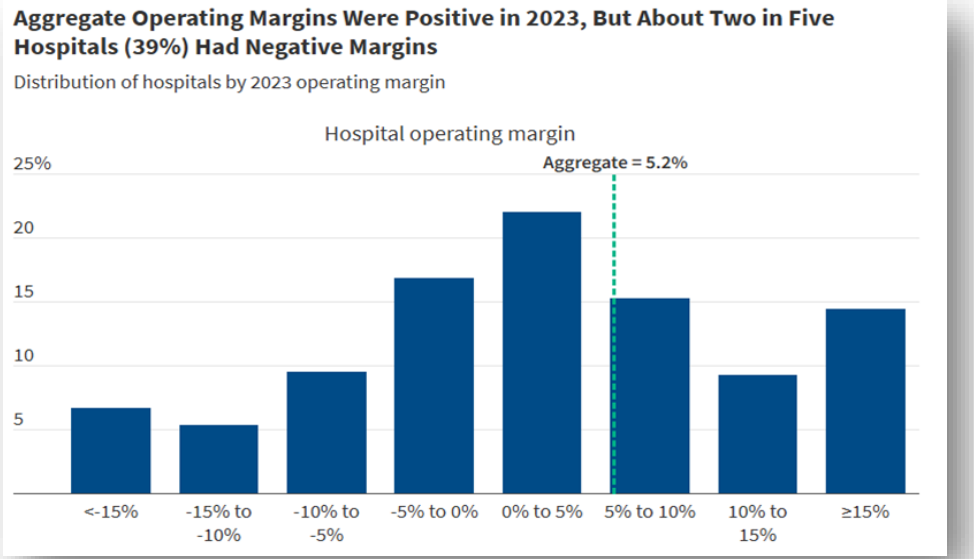
- Calculate potential losses from site neutral proposals by department and impact on operating margin
  - Drug administration, imaging, grandfathering, MedPAC, swing beds
  - Traditional Medicare + commercial contracts with site-of-service differentials
- Identify options for responding to lost revenues by department
  - Assess ability to cover losses with revenue from other departments (i.e., rob from Peter to pay Paul)
  - Explore expense reduction strategies that do not impact access to quality care (e.g., non-clinical RIFs, salaries and benefits, scaling back capital investments)
  - Evaluate service reduction/relocation options, including impact on access to quality care
  - Investigate opportunities for commercial payer rate/volume increases, value-based contracting
  - Consider impact on physician contract renewals
  - Consider affiliation options

# Tell *Your* Story to *Your* Elected Officials and *Your* Community

There's no such thing as an *average* hospital…




https://www.kaufmanhall.com/sites/default/files/2025-02/KH-NHFR_Report-December-2024-Metrics.pdf




https://www.kff.org/health-costs/issue-brief/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others/

# FACT SHEET: PRESIDENT DONALD J. TRUMP ANNOUNCES ACTIONS TO MAKE HEALTHCARE PRICES TRANSPARENT

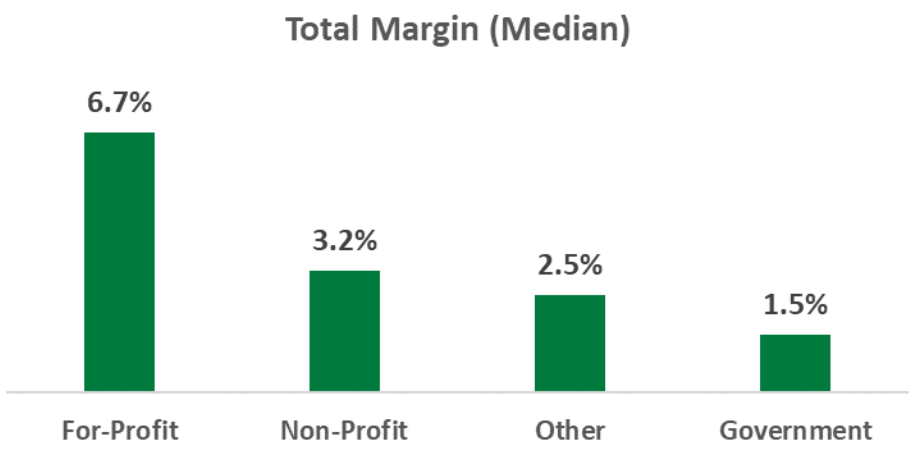
February 25, 2025

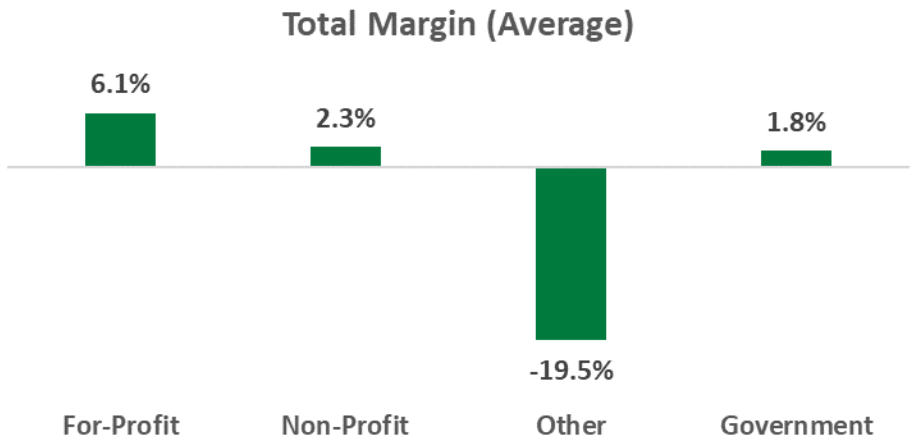
**LOWERING COSTS FOR AMERICAN FAMILIES:** When healthcare prices are hidden, large corporate entities like hospitals and insurance companies benefit at the expense of American patients. Price transparency will lower healthcare prices and help patients and employers get the best deal on healthcare.

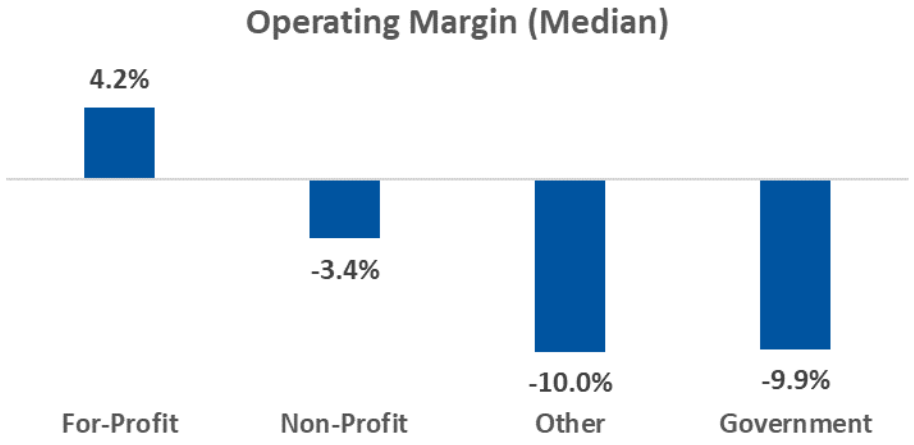
**DELIVERING ON PROMISES TO PUT AMERICAN PATIENTS FIRST:** President Trump is delivering on his promise to once again put American patients first by holding the healthcare industrial complex accountable for delivering transparent prices.

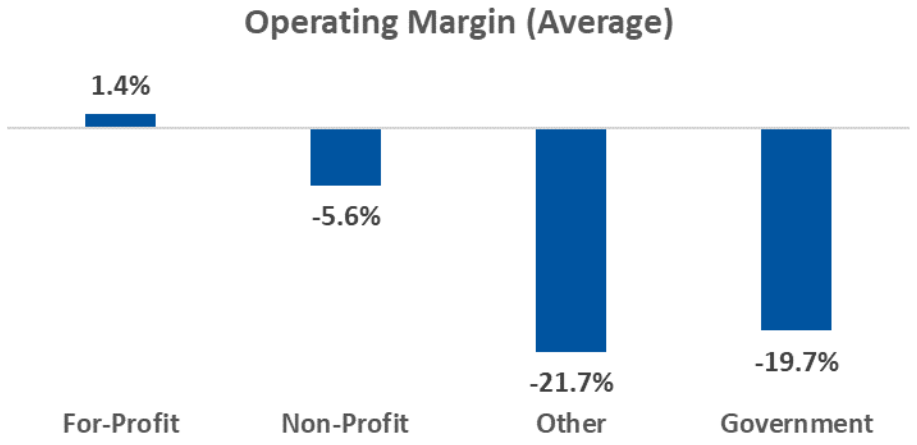
https://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-announces-actions-to-make-healthcare-prices-transparent/

# 2023 PPS Hospital Median and Average Margins



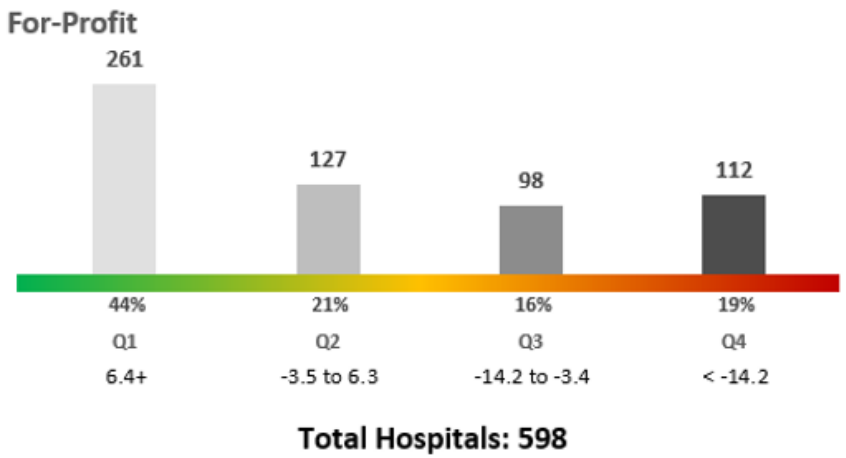



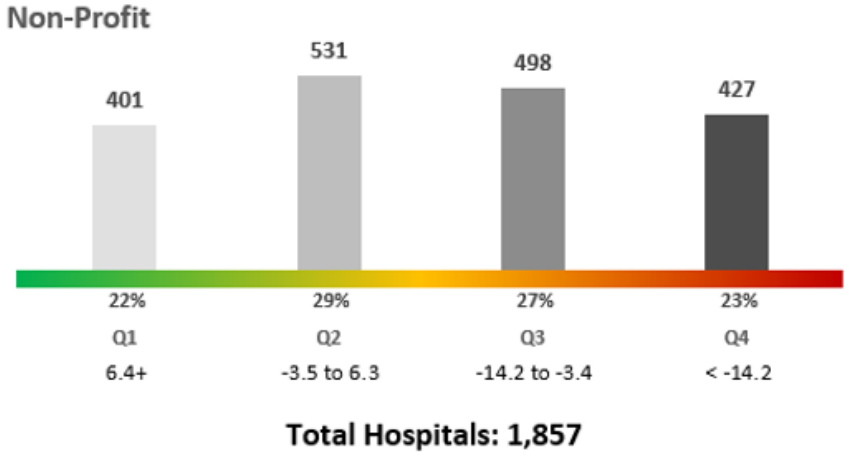



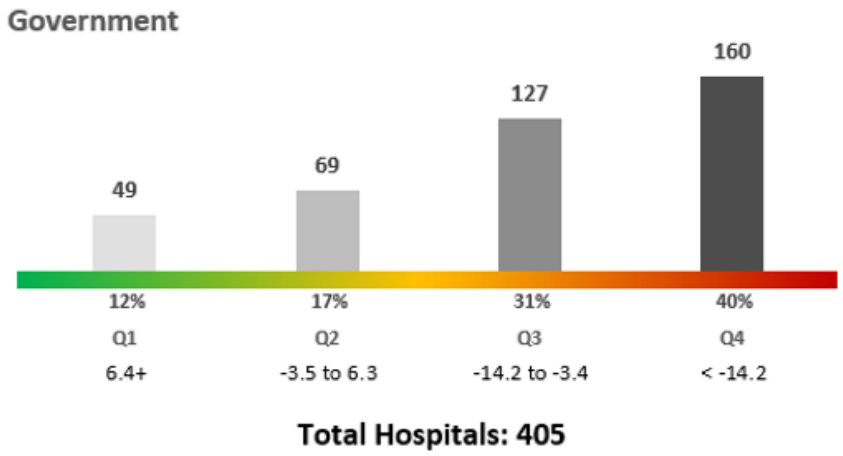



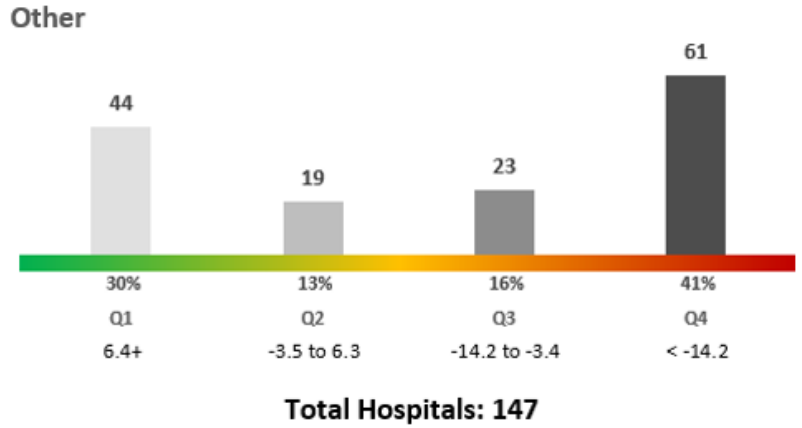

PYA analysis of all PPS hospital 2023 cost report data

# 2023 PPS Hospital Operating Margin – Quartiles By Ownership

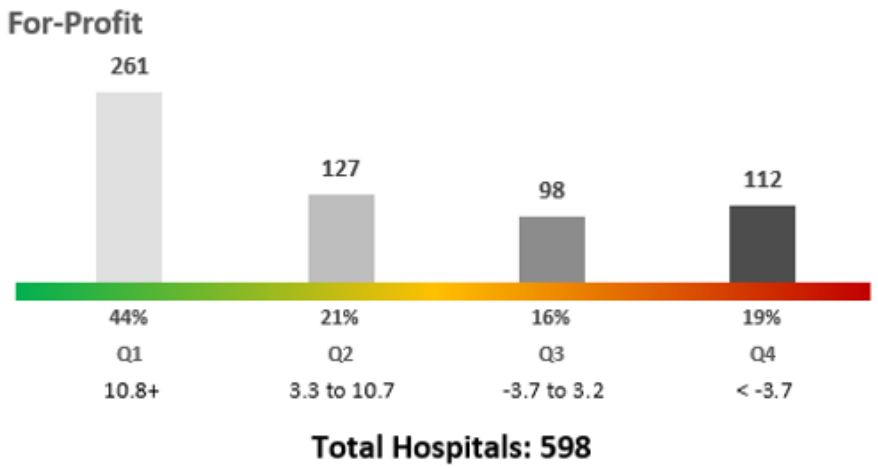


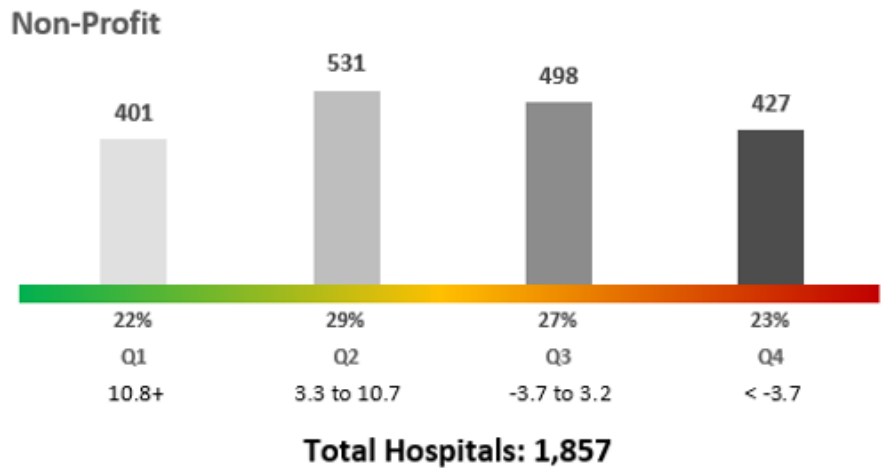



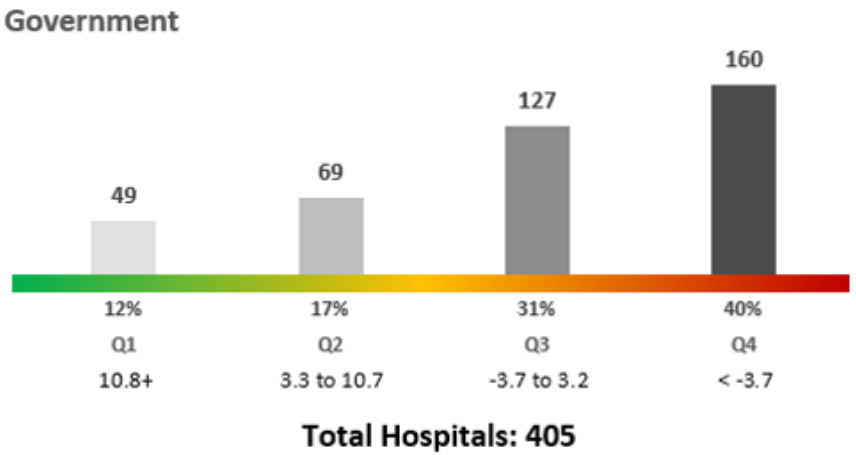



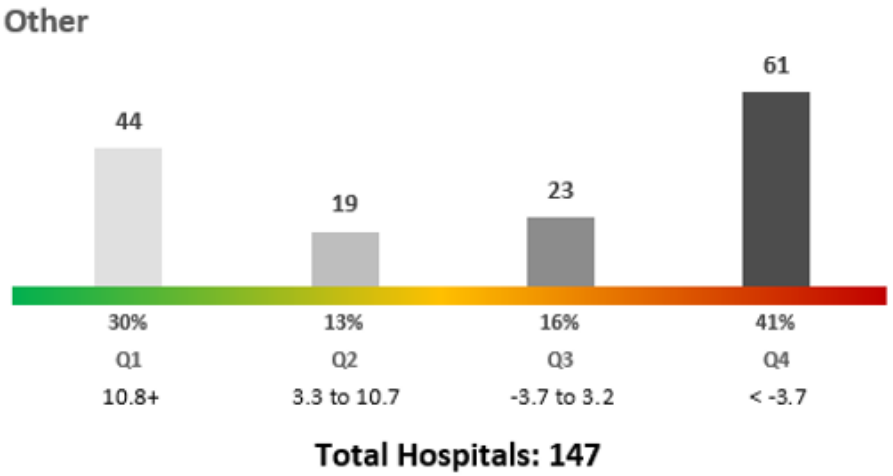



# 2023 PPS Hospital Total Margin – Quartiles By Ownership



# Our Next Healthcare Regulatory Roundup Webinar

## March 27 (Thursday): Washington Update (?)

**Please leave a comment regarding topics for future HCRR webinars!**

# Thank you for attending!

PYA's subject matter experts discuss the latest industry developments in our popular Healthcare Regulatory Roundup webinar series twice each month.

For on-demand recordings of this and all previous HCRR webinars, and information on upcoming topics and dates, please follow the link below.

https://www.pyapc.com/healthcare-regulatory-roundup-webinars/

pyapc.com | 800.270.9629

ATLANTA | CHARLOTTE | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA


A national healthcare advisory services firm providing consulting, audit, and tax services